APPENDIX: C

Home Care Consent for Medication Management Assistance

Client's Name ______________________________ PHN ________________

A. RETURN DEMONSTRATION INDICATES:

_____ Date of client teaching session ______________.
_____ Client can learn with short-term continued teaching.
_____ Client can manage with an assistive device.
_____ Client requires assistance.

B. THE FOLLOWING WAS TRIALED:

_____ Medication organizer poured by client and checked by the Home Care Nurse.
_____ Medications poured into medication organizer by a family member or Home Care Nurse.
_____ Controlled dosage system re-poured and delivered by a pharmacist.

C. LEVEL OF ASSISTANCE:

_____ Client can self-administer.
_____ Client requires reminder only.
_____ Client requires assistance.
_____ Lock box and requires assistance.

D. MEDICATION ASSISTANCE IS REQUIRED RELATED TO:

_____ Visual impairment.
_____ Hearing impairment.
_____ Decreased strength and endurance.
_____ Memory loss ~ MMSE Score ____________.
_____ Abuse of over the counter medications.
_____ Using expired medications.
_____ Using alcohol with medications.
_____ Not completing a course of medication.
_____ Altering medication doses.
_____ Erratic use of medication.
_____ Other (specify) __________________.

E. CONSENT:

I am aware that medications will at times, throughout each day, be given with assistance by a trained HHA. These medications will be packaged by a licensed Pharmacist at the designated pharmacy and then checked and placed on the Medication System by a RN. I agree that any over the counter medication must be brought to the attention of the RN.

When client requires medications in advance because the client will be away from home, arrangements need to be made with the Home Care Nurses at least 24 hours prior to leaving.

Client/Guardian ________________________________ Date ______________________________
(signature)

Home Care Nurse ______________________________ Date ______________________________
(signature)

Drugstore ____________________________________ Physician ___________________________

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